MDHHS
Michigan Department of Health & Human Services

ALE

Lead Services Section
P.O. Box 30037, Suite 410
Lansing, MI 48909
Ph: 517-335-9390
Fx: 517-284-9956

LEAD SAFE HOME PROGRAM APPLICATION

Please call 517-335-9390 if you need assistance in completing this application.

If you are currently living in Benton Harbor, please complete and submit the application

PART 1: OCCUPANT INFORMATION (If Property is vacant, please write "Vacant")

OCCUPANT NAME: _____ TOTAL NUMBER LIVING IN HOUSEHOLD: _____

OCCUPANT TELEPHONE NUMBER: _____ ALTERNATE TELEPHONE NUMBER: _____

OCCUPANT EMAIL ADDRESS: _____ WHEN IS THE BEST TIME TO REACH YOU: _____

PART 2: PROPERTY INFORMATION

PROPERTY ADDRESS: _____ **APT #** _____

CITY: _____ **ZIP:** _____ **COUNTY:** _____

HOW MANY APARTMENTS IN BUILDING: _____ ❑OWNER OCCUPIED ❑RENTAL PROPERTY ❑LAND CONTRACT

HOW DID YOU HEAR ABOUT OUR PROGRAM? _____

HAS THIS PROPERTY EVER BEEN ENROLLED IN A LEAD PROGRAM? IF YES, WHICH ONE? _____

DOES THE PROPERTY CURRENTLY HAVE: ❑WATER ❑ELECTRICITY ❑HEAT ❑PREVIOUS/CURRENT ROOF LEAKS

HAS THE WATER SERVICE LINE BEEN REPLACED OR SCHEDULED TO BE REPLACED? ❑YES ❑NO DATE _____

PART 3: OWNER INFORMATION (Complete only if different from Occupant)

NAME: _____ ❑Individual ❑LLC ❑Partnership ❑Corporation

ADDRESS: _____ TELEPHONE NUMBER: _____

CITY: _____ STATE: ____ ZIP: _____ ALTERNATE TELEPHONE NUMBER: _____

OWNER EMAIL ADDRESS: _____ WHEN IS THE BEST TIME TO REACH YOU: _____

Property owner, please remember to sign page 4 of this application. We cannot proceed without your signature.

By signing below, I (occupant and property owner) permit MDHHS to perform a lead investigation on this property. I agree to fully cooperate in potential lead hazard control work. I understand I must disclose results of lead-activities to potential lessees or buyers of this property. I understand MDHHS is not responsible for uninsured properties or for any damages to real or personal property. I authorize MDHHS to obtain blood lead laboratory results through the Michigan Care Improvement Registry. I agree to let MDHHS share these results privately with authorized program representatives. I authorize the use of information from this application and lead investigation for a research study. I understand the study will not use my personal health information. I answered all questions truthfully and to the best of my knowledge. I understand there is a penalty for false or fake statements. This penalty is from U.S.C. Title 18, sec 1001. It states: "Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly falsifies, or makes, or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years, or both." **I understand signature(s) are required for processing**.

_____	_____	_____
Owner/Landlord Name (please print)	Owner/Landlord Signature	Date
_____	_____	_____
Tenant Name (if applicable, please print)	Tenant Signature (if applicable)	Date

CONTINUE TO PAGE 2

Application Logged In _____ App No: _____ Denial: _____ Reason: _____
BLL: _____ Partnership: _____ Fund Source: _____
Income: _____ Target Area: _____ Funding Maximum: _____
Part V: _____ **Total Application: _____**
APPROVED FOR LSHP ENROLLMENT: _____ _____
If property located in locally serviced HUD/Medicaid area, date verified that property not enrolled locally:

PART 4: OCCUPANT DETAIL: Please complete the table below.

- All occupants, adult and children, must be listed and information complete. Attach an additional sheet of paper, if necessary.
- This Program requires that all children under 6 years old be tested for blood lead poisoning before and after lead reduction work is done on your home. Contact your doctor or county health department to arrange for blood tests. This information will be treated as confidential.
- Homes with children under 6 years of age (Age birth to 5) with an Elevated Blood Lead (EBL) level will be given higher priority.
- Proof of income should be listed for all those who are 18 years of age and older within the household.

The Department of Health and Human Services does not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political belief.

NAME	DATE OF BIRTH	MEDICAID (Y/N)	MEDICAID BENEFICIARY NUMBER	Has this person been told by a doctor/ nurse that he/she has asthma?	Number of times this person visited ER in last year for asthma:	Number of times this person was hospitalized in last year for asthma:	HISPANIC/ LATINO (YES OR NO)	RACE **A**-ASIAN **B**- BLACK **W**- WHITE **H**- HAWAIIAN/ PACIFIC ISLANDER **I**- AMERICAN INDIAN/ ALASKAN

Mail Completed application to:
MDHHS- Lead Services Section
PO Box 30037
Lansing, MI 48909
Fax (517) 284-9956

Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available.

Call 517-335-9390 (TTY users call 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 517-335-9390 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 517-335-9390 (رقم هاتف الصم والبكم:-711:TTY).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 517-335-9390（TTY:711）
Syriac (Assyrian)	ܫܡܘܥܬܐ: ܐܝ ܐܢ ܐܢܬ ܡܗܝܡܢ ܒܠܫܢܐ ܐܬܘܪܝܐ، ܐܝܟ ܒܗ ܕܡܝܢ ܫܘܬܦ ܐܝܬ ܠܟ ܫܝܪܘܬ ܕܥܙܪܐ ܒܠܫܢܐ ܕܝܠܟ ܒܚܠܦ ܠܐ ܡܫܠܡ. ܗܬܘ ܠܝ ܟܠ ܡܝܢ ܕܐܝܬ ܠܟ ܠܡܨܠ ܠ 517-335-9390 (TTY:711)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 517-335-9390 (TTY:711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 517-335-9390 (TTY:711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 517-335-9390 (TTY:711)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-517-335-9390 (TTY ১-711)
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 517-335-9390 (TTY:711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 517-335-9390 (TTY:711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 517-335-9390 (TTY:711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。517-335-9390（TTY:711）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 517-335-9390 (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 517-335-9390 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 517-335-9390 (TTY: 711).

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need the above services, contact the MDHHS Section 1557 Coordinator.

If you believe that MDHHS has failed to provide the above services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: MDHHS Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the MDHHS Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, 4th Floor
P.O. Box 30195
Lansing, MI 48909

517-284-1018 (Main), TTY users call 711, 517-335-6146 (Fax),
MDHHS-ComplianceOffice@michigan.gov

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.